Care Quality Commission

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The Barn House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Barn House is registered to provide nursing care and accommodation for up to 30 people with complex mental health issues, physical disabilities and people who may also be living with dementia. On the day of our inspection 23 people were living at the service, one of these people was in hospital.

The inspection took place on the 7 January 2016 and was unannounced. The inspection followed the Special Measures process to identify if the improvements required had been made.
The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The Barn House is owned and managed by the registered providers; one of the providers is also the registered manager, who was present on the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

The registered provider, registered manager and staff did not show an understanding of the needs of people with mental health issues, dementia and complex physical needs. The information the provider has placed on care websites states the service is a specialised service in supporting people with mental health needs.

Staff did not have written information about risks to people and how to manage these in order to keep them

safe. They did not reflect the individual needs of the person and how their dementia, mental health or physical needs affected their daily life. One person had been diagnosed with epilepsy, but their care plan did not describe guidance to staff on how to manage the risks of them having a seizure. Another person experienced hallucinations but their care plan did not specify how these symptoms could be managed or what staff could do to provide support. At the last inspection, we asked the provider to take action to make improvements on assessing the risks to people's safety; this action had not been completed.

People were not protected from the risk of abuse and improper treatment because staff were not always able to identify situations that constituted ill-treatment. People were left isolated in their rooms without social interactions. People's changes in needs had not been identified which could place them at risk of harm by not receiving the appropriate care. People with mental health problems were not empowered to recover or supported to cope with their symptoms and engage in their own care.

The provider had not ensured robust recruitment checks were undertaken before new staff started work. Full employment histories and references for staff that had started work since July 2015 had not been undertaken.

Most people received their medicines when they needed them. Staff managed the medicines in a safe way and were trained in the safe administration of medicines for the majority of people. However one person had been assessed to receive their medicines covertly and staff were not following this guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

There was a lack of understanding about decisions that people had the capacity to make. Staff did not have a clear understanding of how the person's capacity should be assessed or how decisions should be made in the person's best interest.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people's liberty may be restricted to keep them safe, the provider had not followed the requirements of the Deprivation of Liberty Safeguards (DoLs) because an urgent application under the Deprivation of Liberty Safeguards (DoLS) had expired and the registered provider and or registered manager had not submitted another urgent or standard authorisation to the local authority. This meant that people were being deprived of their liberty illegally. At the last inspection on 21 April 2015, we issued a warning notice under our enforcement process and asked the provider to take action to make improvements by the 15 August 2015, and this action has not been completed.

People were offered a basic choice of food in a written format. There was a choice of meals on offer, which was written on a white board in the main communal area. Kitchen staff told us they would prepare other food for people on request. People were asked about their food preferences for the following day's menu which in most circumstances worked well however people living with dementia would be unlikely to

remember what they had ordered. Staff did not offer choices in an alternate format for example showing a person with dementia two plates of food to choose from.

Staff did not staff consistently respect people or always treat them as individuals, focusing on their needs, abilities and achievements. We heard staff ask people constantly about task focused activities, for example, "Come and have your dinner" and, "Take your medicines." At the last inspection on 21 April 2015, we asked the provider to take action to make improvements on staff empowering people to have their choices and this action has not been completed.

People who used the service did not receive treatment that was personalised specifically for them. We reviewed people's care plans and found that care had not been personalised to meet people's needs or individualised choices. They had not been reviewed on a regular basis and people were not involved with their own plan of care. One person said, "I've never seen a care plan." There was no evidence that people's care followed best practice guidance and was a combined approach looking at people medical, social, cultural and life goals. At the last inspection on 21 April 2015, we asked the provider to take action to make improvements in person centred care and this action has not been completed.

People were referred to some external health professionals such as the GP and SALT (Speech and Language Therapy) team. However if the person needed extra support with mental health issues it was not sought by the registered manager in a timely manner

Staff did not show an understanding of what people were interested in and what people could still do. We saw some people sitting for long periods of time without supportive interaction from staff. Supportive interactions are relationships and communications that we have with people that are affirming and help promote a person's sense of self-worth. Best practice guidance shows one-on-one time is very important to having supportive and emotionally worthwhile social interactions.

People's social and cultural needs were not met. There were people in the service of different cultural backgrounds and religions. These people were not supported to maintain an involvement in their religion or supported to eat the food of their choice from their cultural heritage. People who need care and support have experienced discrimination and stigma which can be detrimental to their mental health and wellbeing and excluded from making decisions for them simply because of their diagnosis or disability. Such as a diagnosis of schizophrenia or by having behaviour that might challenge. One person had been ostracized from their local pub because of the way they looked.

The registered manager and the ethos of the home did not support empower people to continue to fulfil their lives. Activities were limited to people who had capacity to become involved and were not appropriate for people's ages. People who spent time in their rooms or were nursed in bed had no recourse to one to one or social interaction. We did not see any specific activities or pastimes which would be suitable or appropriate to people living with dementia. One member of staff said there were not enough activities. When we asked one person what activities they would like if given the choice, they said, "Go out to town more."

The physical environment was not safe or well designed to enable people with mobility needs or dementia to be as independent as possible for as long as possible. At our last inspection we identified risks to people who had reduced mobility such as hallways dimly lit and trip hazards in hallways. The registered provider had put up some signage but this action was insufficient to keep the environment safe for people with mobility problems and dementia.

The registered manager and the ethos of the home did not support people to fulfil their lives. The registered provider and registered manager did not embrace or drive improvement in relation to best practice in mental health, physical or social care. Practices within the service were institutionalised. Staff did not understand how they promoted the ethos and values of the service. One staff member said "Atmosphere is conducive to the nature of the business." This showed us that the staff lacked understanding of the ethos of the service.

The registered provider and registered manager showed a lack of understanding of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. They have been in breach of regulations since April 2015. They had failed to take action in response to requirements and Warning Notices highlighting risks to the safety of people and the effective operation of the service. The registered providers had failed to address concerns regarding the quality and safety of the service raised by the Commission and partner agencies.

The registered manager did not have a satisfactory system of auditing in place to regularly assess and monitor the quality of the service or manage risks to people in carrying out the regulated activity. We found the registered manager had not undertaken actions suggested in external audits such as Surrey Fire safety. They did not have a robust internal system of quality assurance to make sure improvements to practice were being made. The provider's action plans submitted monthly from August until October stated they had met the requirement of the regulations. However we did not find evidence during our inspection that the required improvements had been made. At the last inspection on 21 April 2015, we asked the provider to take action to make improvements in monitoring the quality of the service and this action has not been completed.

We found the provider had not submitted notifications of safeguarding concerns to the Care Quality Commission (CQC) in a timely manner such as DoLs authorisations and notifications about safeguarding concerns.

The provider had not reported appropriately to the NMC conduct issues of qualified staff.

Staff said they did not receive supervisions; one staff told us "No. We have handover. Nurse will tell you what is expected of you on shifts. We have an annual appraisal. Discuss challenges, best parts of job, knowledge. I have no problems."

Staff had received training in safeguarding adults and were able to evidence to us they knew the procedures to follow should they have any concerns. One staff member said they would report any concerns to the registered manager. They knew of the types of abuse and where to find contact numbers and knew about the local safeguarding team. One staff said "Bring to the attention of my immediate supervisor, they should take higher. If dissatisfied with their response I will contact CQC and relevant bodies." Other training had been implemented; however from observations staff did not put their knowledge into practice.

Confidential and procedural documents were stored safely. We saw copies of the services contingency and emergency plan and the registered manager was able to explain the process in the event of an emergency.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's health and welfare were not always minimised effectively.

The provider had not always protected people from the risk of abuse and improper treatment.

The environment was not a safe environment for people with dementia or mobility needs. T

The provider had not carried out appropriate checks to help ensure they employed suitable people to work at the service or make appropriate referrals to other regulatory bodies when needed.

Medicines were stored and administered safely.

Is the service effective?

Inadequate

The service was not effective.

Staff were not effectively monitoring people's physical or mental healthcare needs, particularly when their needs changed.

Staff did not have the necessary training to support people living with dementia or mental health issues and had not received regular supervision.

The registered manager did not understand their responsibilities under the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. People's freedom was being restricted and there was no system in place to identify if people could make decisions about their care and treatment.

People were not given a choice about what to eat and their mealtime experience was not a positive one.

Is the service caring?

Inadequate

The service was not caring.

Staff did not always take time to speak with people and to engage positively with them.

People were not consistently positive about the care they received, and this was supported by our observations.

People were not always treated in a dignified way.

Some staff showed concern for people in a caring way; however practical action was not always taken to relieve people's distress.

Is the service responsive?

Inadequate

The service was not responsive

Care plans were not person centred and had not been reviewed to help ensure staff had up to date guidance on people's individual needs.

People had not been supported in contributing to planning their own care.

People were not always supported to take part in activities and there were no individualised activities for people who were at risk of isolation

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not ensured that effective quality assurance systems were in place to identify and remedy areas of concern or risk in a proactive manner.

The registered manager and provider did not understand their legal responsibilities or have a good understanding of the key challenges, achievements, concerns and risks for people.

Notifications of incidents were not submitted to the CQC as required by law and the inspection rating was not clearly displayed.

Care Quality Commission

The Barn House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 January 2016 and was unannounced. The inspection was carried out by three inspectors.

We had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information to corroborate our judgements.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. We looked at documents which included seven people's care plans, three staff files, training programmes, medicine records, and four weeks of duty rotas, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

During the inspection we spoke with six people who used the service, four care staff, the registered manager, the registered provider, and a second manager. We also spoke to healthcare professionals after the inspection. We observed care and support in communal areas and looked around all areas of the service.

We last inspected The Barn House on 21 April 2015 and 15 July 2015 where the service's overall rating was inadequate and it was placed in special measures.

Inadequate

Is the service safe?

Our findings

One person told us, "It's Ok, mostly I'm safe." Another person said, "It depends on the staff, as to whether we are safe."

Although people told us overall they felt safe they were not always kept safe. We observed two instances that required us to intervene to make sure people were kept safe.

At our previous inspection we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to Safe care and treatment. The provider submitted an action plan in August 2015 to state they had met the legal requirements. We found at this inspection that the registered provider and registered manager had not made the required improvements to help keep people free from harm.

People were at risk because there was a lack of consistent information on how to manage behaviours that might challenge. Staff told us that five people who lived at the service could present with behaviour that challenged. We observed that staff did not follow the guidance contained in people's care plans when supporting them. We observed on the day that staff did not respond or interact with one person when they screamed. The hourly written log entries stated 'on chair, In bed' they did not contain comment on the welfare of the person or a log of any actions taken to support the person. One person had screamed for 10 minutes without staff intervention. The inspector found that the person had a wet bed and was cold. They told us "I want a drink, I'm hungry."

People were at risk because there was a lack of consistent information on how to manage health related conditions. We looked at six peoples care plans. One person suffered from diabetes, taking both oral medication and receiving insulin injections. This meant the person was at a much increased risk of compromised skin integrity and visual problems, such as diabetic retinopathy. The care plan provided little relevant information about this.

We were told by the registered provider another person was at risk of developing pressure sores and had reddening of their sacral area. A dressing to the area had been applied and a photograph of the area taken nine days later. There was no photograph in the care plan and no formal assessment of skin integrity had been made for over for months which stated 'skin is intact'. This person's health had deteriorated and they had been admitted into hospital. We found that proper steps were not in place to ensure that the person's needs relating to pressure area and pain management were planned and delivered appropriately to ensure their welfare and safety.

People were at risk of harm as the registered manager had not adequately assessed people's moving and handling needs. One person was unable to stand without assistance and required a wheelchair to mobilise. Care plan notes stated "Update to mobility plan 31/12/15 'I have swelling to right leg and fluid and find it difficult to mobilise" Although the registered manager had taken action by calling the GP therewas no

guidance on how staff were to assist the person to mobilise as they could no longer stand unaided. People were at risk because there was a lack of written guidance for staff and the use of inappropriate moving and handling techniques

Risks to people were not assessed in response to incidents such as falls or admission to hospital, there were no plans implemented to mitigate future risks to peoples safety. Two people's care files stated a falls chart had been implemented as they were at risk of falling. However the person's risk assessment was last reviewed over five months ago and stated they 'never had fall'. The risk assessment had not been reviewed after the person had fallen and their risk had increased. Staff did not have the correct information to guide them in supporting the person. There had been on attempt to look at ways to minimise the risk of harm to people from falling.

Action had not been taken to keep people safe in the event of a fire. At our inspection in July 2015, we identified that fire evacuation drills had not taken place. As a result we referred this to the Surrey Fire and Rescue Service who visited the service in July 2015. Action was taken by SFRS against the provider as there were a number of deficiencies in fire safety procedures. These included the lack of an updated fire risk assessment, the need to provide emergency evacuation plans specific to the people living there and the fact that a fire evacuation drill had not been completed. We found these issues had not still been addressed. People and staff were at risk as they were not sufficiently prepared to respond to a fire emergency.

People were not protected against the risks of living in unsafe premises. The premises were not designed to enable people with mobility needs or dementia to be kept safe. The service had narrow, dimly lit hallways which had dark carpeting with a number of slopes and uneven areas of flooring. At our last inspection we identified risks to people who had reduced mobility. The provider had not looked at other ways the risk could be mitigated or not adapted the premises to improve people's quality of life and to promote their wellbeing. At the last inspection, we asked the provider to take action to make improvements to the environment for people with mobility problems and dementia and this action had not been completed.

People were at risk of receiving unsafe care or treatment. This is a continued breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Appropriate recruitment checks were not carried out to ensure that only suitable staff were employed. Full employment histories and references for staff that had started work since July 2015 had not been obtained and the provider did not know what checks should have been made under Schedule 3 of the Health and Social Care Act 2014.
The provider did not take appropriate action where a concern was raised about the fitness of one member of staff who had been subject to an investigation into an incident that occurred at the service. They had not referred the matter to the appropriate regulatory body for further investigation.

The lack of robust recruitment checks and not managing poor practice is a breach of Regulation 19 Fit and Proper persons of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had an interview before they started work. Disclosure and Barring System (DBS) checks had been undertaken for staff. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

People were not always protected from the risk of abuse. because staff were not always able to identify situations that constituted ill-treatment. People were put at risk of harm because staff failed to make a timely referral to the local safeguarding authority when concerns were raised. The provider did not always

understand their responsibilities in relation to safeguarding and as a result two incidents had not been reported appropriately.

This is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Staff were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff said, "I would let my manager know if I suspected abuse. If I had to, I'd go outside, I would whistle blow". The staff member confirmed to us the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. Another member of staff was aware of safeguarding but did not understand what whistleblowing meant. We saw a noticeboard in the ground floor lounge that had contact details of CQC and Reigate and Banstead locality team for people to contact if they needed to.

People received their medicines safely. Medicines were managed and stored appropriately. We examined the Medicines Administration Records (MAR) for ten people. We also observed the dispensing of medication and examined the provider's medication management policy. We asked if staff received regular training or updates. The staff we spoke with told us there was yearly training provided in medicines management by the provider. Our examination of documentation confirmed this. All staff underwent a process of regularly competency checking through direct observation of medicines administration by the manager.

The administration of medicines followed guidance from the Royal Pharmaceutical Society. We noted staff locked the medicine trolley when leaving it unattended and did not sign MAR charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted MAR charts contained relevant information about the administration of certain drugs, for example in the management of anti-coagulant drugs, such as warfarin. Staff were knowledgeable about the medicines they were giving.

All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective. Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medications were safely stored in lockable cabinets. There was a lockable room for the storage of medicines. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge was monitored daily to ensure the safety of medicines. Controlled drugs were stored separately in a locked cupboard. However, no-one at the service was taking controlled drugs on the day of our visit.

People said there were enough staff on duty. One person said "Sometime you have to wait, but eventually someone comes." There was one qualified nurse and three or four care staff were on duty for 22 people during the day. At night there was one qualified nurse and one care staff. In addition to the care staff and qualified staff a cleaner and kitchen staff and manager and both providers worked at the home. The registered manager said that a manager was present in the service Monday to Friday but that this was flexible depending on people's needs.

Inadequate

Is the service effective?

Our findings

People told us that they could not always make the choices that they wanted. One person said "I don't get to go out often". Another person said "We have to follow the routine."

At our previous inspection we found breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to Consent. The provider submitted an action plan in August 2015 to state they had met the legal requirements. We found at this inspection that the registered provider and registered manager had not made the required improvements to help keep people free from harm and support people who lacked capacity to make choices. The registered provider and registered manager did not have suitable arrangements in place to ensure that staff obtained consent from people and as a result people faced daily restrictions on how they lived their lives.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's rights were not always protected because the registered providers and staff lacked an understanding of the MCA and DoLS and how to apply it to people's care. Staff did not have a clear understanding of how the person's capacity should be assessed or how decisions should be made in the person's best interest. The registered providers did not show an understanding that the MCA was separate from the application to deprive someone of their liberty. One person lacked capacity to manage their finances however the registered manager had submitted a DoLS application for personal care and had not mentioned finances. Mental capacity assessments for individual decisions that were undertaken had not been completed.

In December 2015 concerns were raised by an independent advocate that two people were deprived of their liberty (that they had to remain in the service and not go out unescorted) but that an urgent application under DoLS had expired and another one had not submitted for an urgent or standard authorisation to the local authority that funded their care.

The registered manager had failed to act in accordance with the MCA and to protect the rights of people who were unable to give consent. One person was subject to receiving care under a section of the Mental Health Act 1983. It stated they lacked insight into their care needs and lacked capacity to make decisions

regard to their care and accommodation. However there have been no capacity assessments regarding their care or application for DoLS for this person. The registered manager was restricting the person's liberty and the necessary safeguards were not in place.

One person did not have a mental capacity assessment in relation to their medicines. We had been told by the registered manager that no-one received their medicines covertly, that is, without their knowledge or permission. However, when we spoke with the registered nurse we were told one person did receive medicines covertly.

People's rights were not always protected as the registered manager had not followed the MCA. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat however we found that mealtimes were not always a pleasant experience for people. Staff did not interact with people and the dining area was uninviting with plastic beakers for people to drink from. One person told us "The food is ok, not a great choice."

Meals were served at different times with those that needed support to eat being served first. People who could eat independently had lunch in the upstairs dining room. The registered provider told us "We have two sittings. First at 12pm for people who need assistance and second for people who are more independent." However from our observations this was not always people's choice. One person came into the lounge and went to sit at the dining table. A staff member asked the person to go upstairs. The person said, "I want to eat down here". Another staff said, "Go upstairs as your food is there." The person replied, "No I want to eat down here" and sat at the table. Staff then said to the person "Your food is upstairs" and left the room. When one person got up from the table after finishing their meal two staff told him to "sit down and wait for dessert." The person said "No" and went and sat in a lounge chair.

In the evening people were given a choice of either jacket potato with cheese and bread or a sandwich. Some people struggled to cut them up or take the filling out; one person said the potato was "Bloody hard". Staff were sitting in the lounge but none offered to help people who needed it. One person told us the food was "Never served very hot."

The menu was based on a four week rota. There was a choice of meals on offer displayed in the lounge and kitchen staff told us they would prepare other food for people on request. However we saw no evidence that choice was given as everybody was served the same lunch.

We noted care staff asked people about their food preferences for the following day's menu. Whilst in most circumstances this worked well some people who used the service would be unlikely to remember what they had ordered the previous day.

People's nutritional care plans were not consistently kept up to date. Documents that helped reduce the risk of malnutrition were not updated and risks to people with complex needs in their eating and drinking had not been identified. One member of staff told us some people were at risk and needed support with their food and drink however there was a lack of guidance to staff.

Staff appeared knowledgeable about people's likes and dislikes and dietary requirements, including those requiring special diets for religious or cultural reasons. We observed good communication between kitchen and staff, who advised the chef of changes made to people's diets following input from visiting

professionals, such as dieticians and Speech and Language Therapists.

Staff regularly requested the GP to visit however staff did not always respond to changes in people's health needs or ensure that advice from external healthcare professionals was followed. For example people who had pressure wounds which were deteriorating had not been referred for specialist support. One healthcare professional told us that they would expect that qualified nurses should have the knowledge and skills to offer prevention and management of pressure ulcers to a certain level. Staff supported people to maintain their health and noted when people's health care needs changed, One staff member told us "If not feeling well call person in charge". If they have a bruise we have to call manager. They will call hospital and do scan for person".

Staff had received some training to develop their skills through distance training and e- learning. There were no competency assessments of staff undertaken to ensure they were putting their learning into best practice. Staff did not fully understand or consistently demonstrate their knowledge or how to put their training into practice. Staff had not received training in managing behaviour that might challenge or positive behaviour supported and this was confirmed in the provider's PIR. One person's care plan stated that 'X is verbally aggressive'. Care staff had not had training in identifying or preventing pressure wounds. The lack of training, coupled with a lack of guidance, meant that people were placed at risk of harm.

Not all staff had regular supervision so were not always effectively supported.

Inadequate

Is the service caring?

Our findings

People had mixed views about the caring nature of staff, one person said, "They are ok." Another person said "The manager is usually available."

At our previous inspection we found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to person centred Care. The provider submitted an action plan in August 2015 to state they had met the legal requirements. We found at this inspection that the registered provider and registered manager had not made the required improvements to ensure peoples care was personalised to their need.

People who used the service did not receive treatment that was personalised specifically for them. One person's care plan stated; personal care preferences 'I do like nail polish on my finger nail. I would like a bath in the evenings. I like care assistants to apply a little make up'. We observed the person did not have make up or nail varnish on during the inspection. Other people in the lounge had no shoes and were sitting wearing socks, some of which had holes in.

We did not always observe appropriate interaction between people and staff. For example, we noted one person had arrived at the ground floor at lunchtime, requesting, in a calm manner, to have their lunch there. Lunches at the service were served both on the ground floor and the first floor. The person's request was ignored and they were told to go back upstairs. When they repeated their request, they were once again told to go upstairs. We observed People's rooms had jugs of water and glasses on their tables however these were placed out of reach to them. Three people who had limited mobility were sitting in chairs and their drink was out of reach

People or their representatives had not had regular and formal involvement in their care planning. People were invited to comment on care on their formation but people's views were not formally sought on subsequent reviews and risk assessments. Consequently, there were no opportunities to alter the care plans if the person did not feel they reflected their care needs accurately

Practices within the service were institutionalised. Staff did not understand how they promoted the ethos and values of the service. One staff member said "Atmosphere is conducive to the nature of the business." Staff did not show an understanding on the impact of a person's mental health on the rest of their lives.

People's rooms had jugs of water and glasses on their tables however these were placed out of reach to them. Three people who had limited mobility were sitting in chairs and their drink was out of reach. People did not have the facilities to make their own drinks or snacks so they were not able to be as independent as they would have liked and there were set routines which affected how people accessed food and drink. On one occasion a person was screaming, their care plan stated when they did this it was an indication they were thirsty and hungry. Staff did not offer the person a drink. The inspector intervened and the person said "I am so thirsty; please can I have a drink." No attempt was made to offer them a cup of tea or drink. We asked the staff member how people who were able to could make their own drinks if they wanted to. They

explained to us that people did not make them, they followed the routine and were given drinks at set times throughout the day.

The provider had put in place rules and a way of doing things that directed people what to do. There was a set regime in the house which people were not involved in deciding. For example, time for getting up, drink times, medicine times and activity times. People did not realise they did not have to follow this because an alternative choice was not offered. One staff member told us everybody was woken up by the night staff, they said "We start work 8am. All up before then, night staff give breakfast, start personal care 8-9."

People's rooms were plain and lacked personalisation or familiar things. People that had mobility needs and physical nursing needs did not have the appropriate beds; all but one person had single divan beds. One person had swollen legs and would have benefitted from having a bed that could tilt.

People who used the service did not receive treatment that was personalised specifically for them. This is a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke to had an understanding of what caring for people meant. One staff member said "Encourage and talk to them. Make them feel like they in own home. Do what they want." We asked staff how they supported people to maintain their dignity and privacy. We were told that people were always cared for by staff members of the same gender, which was a policy of the provider.

We asked the registered provider how people's preference to care was respected. They told us; "Bathing, if don't want we keep reminding at intervals. They tell us when they want a bath. Some people like showers every day, it's their choice". Also said "Female residents are cared for by female staff for personal care."

Inadequate

Is the service responsive?

Our findings

At our previous inspection in April 2015 we found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to person centred Care. The provider submitted an action plan in August 2015 to state they had met the legal requirements. We found at this inspection that the registered provider and registered manager had not made the required improvements to ensure people's social and cultural needs were met.

One person said that they did not go out and, "I only get to go out if my family take me." And "It's so depressing in the lounge, everyone sitting round the edge; I don't like to go in there." The person also said that they "I want to move, the care could be better in other places."

There was not a dedicated activities co-ordinator and the provider had not been able to recruit anybody to this role. The provider said that although some activities were provided it was, "Difficult to do".

There was an activities programme for people which was displayed in the main lounge. The notice stated the activities available were Passive exercises, Daily walks and daily shopping outings, ball games, individual discussion, group discussion, skittles, music, physio ball, exercise, reminiscence and darts. The information on the noticeboard did not include dates or times where activities would take place. We checked people's activity records and saw that these had not always taken place.
People's social needs were not met and for those that were unable to leave the service independently they were unable to go out. During our inspection the atmosphere in the main lounge was subdued with people sitting in chairs with limited interaction with staff. Activities had not been tailored to people's individual needs. When staff did try to engage in an activity which involved a ball they did not explain to people what they were doing or why. Whilst this was happening there was music playing. Staff told us that people's social needs were met by watching television together or by them playing music. One person enjoyed colouring and was given a book and pens which they appeared to enjoy.

The environment lacked stimulation for people living with dementia The lack of activities is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care plans contained incomplete pre-admission assessments and lack of detail about what care was to be provided to people. Care plans and daily records for were legible and indexed. The care plans we looked at contained very little information about personal and social histories however people's choices and preferences were documented. The daily records showed that these were taken into account when people received care. People and their representatives had not had regular and formal involvement in their care planning. and risk assessment. People were invited to comment on care on their formation but people's views were not formally sought on subsequent reviews and risk assessments. Consequently, there were no opportunities to alter the care plans if the person did not feel they reflected their care needs accurately.

We reviewed people's care plans and found that care had not been personalised to meet people's needs.

Care plans lacked personalisation and primarily focused on tasks such as personal care and mobility needs. They did not show how the experience of dementia or people's mental health illness affected people as this varied widely from person to person. Care plans lacked an element of dementia focused care information such as memory assessments, biographies and personality traits.

People's needs were not always assessed appropriately and care and treatment was not always planned and delivered to reflect their individual care plan. One person enjoyed Caribbean food, including salads and rice. This information was not recorded nor were they offered food that met their cultural needs or preferences

Another person had a communication care plan which stated they needed to be encouraged to communicate using photo cards. Staff should speak to them slowly and softly so they could understand what was being said to them. Distractions such as noise from the TV or radio should be minimised to promote their communication skills. This care plan had not been updated or reviewed. At no times during the inspection were staff seen using the agreed preferred method to communicate with them. This meant that this person was socially isolated as a result.

Care plans lacked personalisation and primarily focused on tasks such as personal care and mobility needs. They did not show how the experience of dementia or people's mental health illness affected people as this varied widely from person to person. They lacked an element of dementia focused care information such as memory assessments, biographies and personality traits.

Care plans were not appropriate to meet people's needs or reflected people's preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's views were not obtained and they were not asked to complete feedback questionnaires so that they could give an opinion on how they wanted their care to be delivered.

There was not an established or effective system for identifying, receiving, and recording, handling and responding to complaints. The last complaints logged were in 2013but complaints had been made from people who used the service, neighbours and external professionals since that date that had not been responded to or investigated.

Inadequate

Is the service well-led?

Our findings

One person said "The managers are always here, I can't tell them everything in case they don't like it." Relatives told us the registered manager was, "Always around" and that the registered provider mostly dealt with an issues.

At our previous inspection in April 2015 we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to person centred Care. The provider submitted an action plan in August 2015 to state they had met the legal requirements. We found at this inspection that the registered provider and registered manager had not made the required improvements to ensure good governance of the service.

The service was been owned and managed by the providers for 29 years however we found that practices within the service were institutionalised. Staff did not understand how they promoted the ethos and values of the service. One staff member told us the atmosphere is "Conducive to the nature of the business." but it was unclear whether they knew what this meant to people who used the service. Staff told us that they were satisfied with the quality of the service but said there was "Room for improvement."

There was a lack of understanding by the registered provider and manager about the changes to regulations that underpin providing care that was safe, effective, responsive, caring and well-led.

Staff told us they generally felt supported but not all staff told us they understood their roles and responsibilities. Staff felt their views were not always sought or valued. The culture of the service was not always open and transparent. We looked at staff meeting minutes and saw that there was no opportunity to share their views to improve the quality of the service.

People were at risk of harm because there was a lack of established systems to assess, monitor and improve the quality and safety of the services. Some procedures and documents were in place to assess the quality of the service and identify any areas of concern however, they had not identified specific issues or put plans in place to rectify any issues identified.

Audits were not regularly undertaken in relation to care plans, mobility needs, MCA and DoLS. Other audits had not been regularly undertaken such as monitoring people's pressure wounds. Quality assurance systems had not ensured that people were protected against some key risks as described in this report. Regular monitoring of staff practice in relation to activities would have identified that some people were not being supported to have 'quality' days. This comes from the Nice quality standards of mental wellbeing for older people in care homes guidance. NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care.

A monthly audit of risk assessments had not been carried out since August 2015 and the last audit stated that they had 'Reviewed all' and, 'No issues' had been found. It was not clear what had been reviewed, what the findings were and if any action needed to be taken as a result. There was a failure to identify areas of

concern we found at this and previous inspections related to risk management, specifically regarding behaviours that may challenge and moving and handling.

Accident audits had not been undertaken since August 2015 and did not demonstrate that the information had been used to determine whether there were any patterns in when or why individuals might have fallen or injured themselves. The registered provider told us they did three monthly analyses but not done this as they had been "Busy" with Christmas and "Buying presents for residents." This could mean that patterns in falls or injuries were not identified and steps to mitigate risks to people would be missed.

The provider and registered manager did not always identify risks did not have strategies to minimise these risks to make sure the service ran smoothly. There had been incidents within the service but the provider had not submitted the appropriate notification to CQC as required by law. For example, incidents where the police had been involved and safeguarding concerns. This showed the provider was not meeting their legal requirements within their registration or monitoring or mitigating the risk to people in relation to health, safety and welfare.

The registered provider and manager had not maintained complete records to monitor known risks to service user's health. There was no indication that concerns over people's deterioration in health had been raised or that action had been taken. It was unclear how people's health was being monitored and responded to when changes arose because the provider had not maintained an accurate record.

The registered manager did not effectively undertake processes to regularly assess and monitor the quality of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered provider and registered manager had failed to display the previous inspection rating at the service. The failure to display the rating meant that people would not have an easy way to understand the performance of the service. During our inspection we were told that the inspection rating was displayed on a noticeboard in the lounge but when we checked this was not displayed.

We asked about 'duty of candour' and its relevance to the care and support of people living at the service. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with people and other 'relevant persons' (people acting lawfully on behalf of people using services) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents .The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The registered manager we spoke with was not able to describe its relevance and application.

The lack of good governance is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014